MAY 27 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13352

1. PLACE OF DEATH
County: Miller
Township: Jim Henry
City: ..... (No. ....., ... St. ..... Ward)
Registration District No. 6
Primary Registration District No. 5759 B3
File No. 41
Registered No. .....

2. FULL NAME: Adelaide Hollenbeck

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: Herman Hollenbeck

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 7 1831

7. AGE: Years 99 | Months 1 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): Germany

PARENTS
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Anna Lawsuer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Germany

14. INFORMANT: Herman Gerling
(Address): Meta Mo

15. FILED 4/19, 19 30 John E. Schwiedermann REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 17 1930

17. I HEREBY CERTIFY, That I attended deceased from 12/28, 1929, to 4/17, 1930 that I last saw h. alive on 4/17, 1930, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer (Uterus)
Senility
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): No
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: —
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF: —
WAS THERE AN AUTOPSY? No —
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) S. L. Gaston, M. D.
4/19, 1930 (Address) Meta.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St Cecilia Cemetery Meta Mo
DATE OF BURIAL: 4/19 1930

20. UNDERTAKER: Newman H Strop
ADDRESS: Meta Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.